



U.S. Department of State
MEDICAL HISTORY AND PHYSICAL EXAMINATION WORKSHEET
For use with DS-2053 or DS-2054

OMB No. 1405-0113
EXPIRATION DATE: 08/31/2014
ESTIMATED BURDEN: 35 minutes
(See Page 2 - Back of Form)

Name (Last, First, MI)		Exam Date (mm-dd-yyyy)
Birth Date (mm-dd-yyyy)	Passport Number	Alien (Case) Number

1. Past Medical History (indicate conditions requiring medication or other treatment after resettlement and give details in Remarks)
NOTE: The following history has been reported, has not been verified by a physician, and should not be deemed medically definitive.

<p>No Yes</p> <p><input type="checkbox"/> <input type="checkbox"/> General</p> <p><input type="checkbox"/> <input type="checkbox"/> Illness or injury requiring hospitalization (including psychiatric)</p> <p><input type="checkbox"/> <input type="checkbox"/> Cardiology</p> <p><input type="checkbox"/> <input type="checkbox"/> Heart disease</p> <p><input type="checkbox"/> <input type="checkbox"/> Hypertension (high blood pressure)</p> <p><input type="checkbox"/> <input type="checkbox"/> Cardiac arrhythmia</p> <p><input type="checkbox"/> <input type="checkbox"/> Pulmonology</p> <p><input type="checkbox"/> <input type="checkbox"/> History of tobacco use Current use <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> <input type="checkbox"/> Asthma</p> <p><input type="checkbox"/> <input type="checkbox"/> Chronic obstructive pulmonary disease (emphysema)</p> <p><input type="checkbox"/> <input type="checkbox"/> History of tuberculosis (TB) disease Treated <input type="checkbox"/> Yes <input type="checkbox"/> No Current TB symptoms <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> <input type="checkbox"/> Neurology and Psychiatry</p> <p><input type="checkbox"/> <input type="checkbox"/> History of stroke, with current impairment</p> <p><input type="checkbox"/> <input type="checkbox"/> Seizure disorder</p> <p><input type="checkbox"/> <input type="checkbox"/> Major impairment in learning, intelligence, self care, memory, or communication</p> <p><input type="checkbox"/> <input type="checkbox"/> Major mental disorder (including major depression, bipolar disorder, schizophrenia, mental retardation)</p> <p><input type="checkbox"/> <input type="checkbox"/> Use of drugs other than those required for medical reasons</p> <p><input type="checkbox"/> <input type="checkbox"/> Addiction or abuse of specific* substance (drug) *amphetamines, cannabis, cocaine, hallucinogens, opioids, phencyclidines, sedative-hypnotics, and anxiolytics</p> <p><input type="checkbox"/> <input type="checkbox"/> Other substance-related disorders (including alcohol addiction or abuse)</p> <p><input type="checkbox"/> <input type="checkbox"/> Ever taken action to end your life</p>	<p>No Yes</p> <p><input type="checkbox"/> <input type="checkbox"/> Ever caused SERIOUS injury to others, caused MAJOR property damage or had trouble with the law because of medical condition, mental disorder, or influence of alcohol or drugs</p> <p><input type="checkbox"/> <input type="checkbox"/> Obstetrics and Sexually Transmitted Diseases</p> <p><input type="checkbox"/> <input type="checkbox"/> Pregnancy Last menstrual period Date (mm-dd-yyyy) _____</p> <p><input type="checkbox"/> <input type="checkbox"/> Sexually transmitted diseases, specify _____</p> <p><input type="checkbox"/> <input type="checkbox"/> _____</p> <p><input type="checkbox"/> <input type="checkbox"/> Endocrinology and Hematology</p> <p><input type="checkbox"/> <input type="checkbox"/> Diabetes mellitus</p> <p><input type="checkbox"/> <input type="checkbox"/> Thyroid disease</p> <p><input type="checkbox"/> <input type="checkbox"/> History of malaria</p> <p><input type="checkbox"/> <input type="checkbox"/> Other</p> <p><input type="checkbox"/> <input type="checkbox"/> Malignancy, specify _____</p> <p><input type="checkbox"/> <input type="checkbox"/> Chronic renal disease</p> <p><input type="checkbox"/> <input type="checkbox"/> Chronic hepatitis or other chronic liver disease</p> <p><input type="checkbox"/> <input type="checkbox"/> Hansen's Disease <input type="checkbox"/> Multibacillary <input type="checkbox"/> Paucibacillary Treated <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> <input type="checkbox"/> Visible disabilities (including loss of arms or legs), specify _____ _____ _____</p> <p><input type="checkbox"/> <input type="checkbox"/> Other requiring treatment, specify _____ _____ _____</p>
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2. Physical Examination (indicate findings and give details in Remarks)

☐ No ☐ Yes Applicant appears to be providing unreliable or false information, specify _____

Height _____ cm Weight _____ kg Visual Acuity at 20 feet: Uncorrected L 20/ _____ R 20/ _____
B _____ / _____ (mmHg) Heart rate _____ /min Respiratory rate _____ /min Corrected L 20/ _____ R 20/ _____

***N, normal; A, abnormal; ND, not done**

<table style="width:100%;"><tr><td style="width:10%; text-align: center;">N*</td><td style="width:10%; text-align: center;">A*</td><td style="width:10%; text-align: center;">ND*</td><td></td></tr><tr><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td><td>General appearance and nutritional status</td></tr><tr><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td><td>Hearing and ears</td></tr><tr><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td><td>Eyes</td></tr><tr><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td><td>Nose, mouth, and throat (include dental)</td></tr><tr><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td><td>Heart (S1, S2, murmur, rub)</td></tr><tr><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td><td>Breast</td></tr><tr><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td><td>Lungs</td></tr><tr><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td><td>Abdomen (including liver, spleen)</td></tr><tr><td></td><td></td><td></td><td>Fundal height _____ cm</td></tr></table>	N*	A*	ND*		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	General appearance and nutritional status	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hearing and ears	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nose, mouth, and throat (include dental)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart (S1, S2, murmur, rub)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Breast	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lungs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Abdomen (including liver, spleen)				Fundal height _____ cm	<table style="width:100%;"><tr><td style="width:10%; 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3. Additional Testing Needed Prior to Approving Medical Clearance

No Yes

☐ ☐ Physical examination or laboratory results contradict medical history

☐ ☐ Referral prior to departure If yes, provide results _____

☐ ☐ Referral prior to departure If yes, provide results _____

4. Follow-up Needed After Arrival

☐ No ☐ Yes, within 1 week ☐ Yes, within 1 month ☐ Yes, within 6 months

☐ For continuing medication, list type, dose, and frequency (*Exception: For TB medications, use Part 4 of DS-2053 or DS-2054 form*) _____

☐ For continuing other treatment, specify _____

5. Remarks (*Describe any abnormal history, abnormal findings, and resulting interventions*)

PAPERWORK REDUCTION ACT AND CONFIDENTIALITY STATEMENTS

PAPERWORK REDUCTION ACT STATEMENT

Public reporting burden for this collection of information is estimated to average 35 minutes per response, including time required for searching existing data sources, gathering the necessary documentation, providing the information and/or documents required, and reviewing the final collection. You do not have to supply this information unless this collection displays a currently valid OMB control number. If you have comments on the accuracy of this burden estimate and/or recommendations for reducing it, please send them to: A/GIS/DIR, Room 2400 SA-22, U.S. Department of State, Washington, DC 20522-2202.

CONFIDENTIALITY STATEMENT

AUTHORITIES The information asked for on this form is requested pursuant to Section 212(a) and 221(d) and as required by Section 222 of the Immigration and Nationality Act. Section 222(f) provides that the records of the Department of States and of diplomatic and consular offices of the United States pertaining to the issuance and refusal of visas or permits to enter the United States shall be considered confidential and shall be used only for the formulation, amendment, administration, or enforcement of the immigration, nationality, and other laws of the United States. Certified copies of such records may be made available to a court provided the court certifies that the information contained in such records is needed in a case pending before the court.

PURPOSE The U.S. Department of State uses the facts you provide on this form primarily to determine your classification and eligibility for a U.S. immigrant visa. Individuals who fail to submit this form or who do not provide all the requested information may be denied a U.S. immigrant visa. Although furnishing this information is voluntary, failure to provide this information may delay or prevent the processing of your case.

ROUTINE USES If you are issued an immigrant visa and are subsequently admitted to the United States as an immigrant, the Department of Homeland Security will use the information on this form to issue you a Permanent Resident Card, and, if you so indicate, the Social Security Administration will use the information to issue a social security number. The information provided may also be released to federal agencies for law enforcement, counterterrorism and homeland security purposes; to Congress and courts within their sphere of jurisdiction; and to other federal agencies who may need the information to administer or enforce U.S. laws.